CLEARWATER
BRIGHT AND BEAUTIFUL · BAY TO BEACH

Request for Proposal

No. 44-24

Dental and Vision Insurance

City of Clearwater

100 South Myrtle Avenue

Clearwater, Florida 33756

Date Solicitation Issued: May 2, 2024

Proposal Due Date: May 30, 2024

Plan Effective Date: January 1, 2025

SUBMIT PROPOSAL TO:	It is recommended that proposals are submitted electronically through our bids website at:https://www.myclearwater.com/business/rfp. Proposers may mail or hand-deliver proposals to the address below. E-mail or fax submissions will not be accepted. Use label at the end of this solicitation package **If responses are delivered electronically, hand-delivered copies are not required.** City of Clearwater Attn: Procurement Division 100 S Myrtle Ave, 3rd Fl, Clearwater FL 33756-5520 or PO Box 4748, Clearwater FL 33758-4748 No responsibility will attach to the City of Clearwater, its employees or agents for premature opening of a proposal that is not properly addressed and identified.	**Request for Proposal** **City of Clearwater**

Proposal Title: Dental & Vision Insurance

PROPOSAL IS DUE: May 30, 2024, at 10:00pm **DEADLINE FOR WRITTEN QUESTIONS: MAY 16, 2024, AT 3:00 P.M.** **MUST BE SUBMITTED TO lori.vogel@myclearwater.com** **Plan Effective Date: January 1, 2025**	ISSUE DATE: May 2, 2024

Attachments: Attachments 1-14 listed under SECTION VI in this RFP will be released via secure email by the City's Agent of Record: Gehring Group

Submittal Instructions: It is recommended that responses are submitted electronically through our bids website at https://www.myclearwater.com/business/rfp.

For responses mailed and/or hand-delivered, firm must submit one (1) signed original (identified as ORIGINAL) response, five (5) copies of the response and one (1) copy in an electronic format, on a disc or thumb drive, in a sealed container using the label provided at the end of this solicitation.
NOTE: If submitting proposals electronically, copies are not required.

Addenda: From time to time, addenda may be issued to this Request for Proposal. Any such addenda will be posted to the City's website at https://www.myclearwater.com/business/rfp. Prior to submitting a response to this solicitation, it is the vendor's responsibility to confirm if any addenda have been issued.

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Request for Proposal – Dental & Vision Insurance

SECTION I: RFP Overview

Coverage Effective Date: January 1, 2025

The City of Clearwater (hereafter referred to as "the City") is seeking experienced and qualified firms that demonstrate the highest level of ability to provide the following lines of insurance coverage:

- **Dental Insurance**
  - Fully-Insured Quotes
    - DHMO Plans
    - DPPO Plan
- **Vision Insurance**
  - Fully-Insured Quote

Due Date: It is recommended that proposals are submitted electronically through our bids website at https://www.myclearwater.com/business/rfp by the Response Deadline outlined in the Project Details.

Proposers may mail or hand-deliver proposals to the address below. E-mail or fax submissions will not be accepted. Use label at the end of this solicitation package
City of Clearwater
Attn: Procurement Division
100 S Myrtle Ave, 3rd Fl, Clearwater FL 33756-5520
or
PO Box 4748, Clearwater FL 33758-4748

Proposals will be received at this address. Proposers may mail or hand-deliver proposals; e-mail or fax submissions will not be accepted.
No responsibility will attach to the City of Clearwater, its employees or agents for premature opening of a proposal that is not properly addressed and identified.

Late Proposals. The proposer assumes responsibility for having the proposal delivered on time at the place specified. All proposals received after the date and time specified shall not be considered. Proposals that are hand delivered will be returned unopened to the proposer. The proposer assumes

the risk of any delay regardless of whether sent electronically, by mail or by means of personal delivery. It shall not be sufficient to show that you mailed or commenced delivery before the due date and time. All times are Clearwater, Florida local times. The proposer agrees to accept the time stamp in the City's Procurement Office as the official time.

Firms interested in submitting a response to this RFP, agree not to contact (lobby) any employee or agent of the City at any time during the solicitation period and the selection process. All oral or written inquiries are to be directed to Lori Vogel, Procurement Manager, at lori.vogel@myclearwater.com. Any other contact will be considered inappropriate and subject your response to rejection/disqualification.

The City reserves the following rights: to waive informalities in any proposal; to reject any or all proposals or portions of proposals; to accept any proposal or portions of proposals deemed to be in the best interest of the City; and to negotiate or refuse to negotiate with any offer.

SECTION II: General Information

SCOPE AND PURPOSE

The specifications include the complete set of requirements and proposal forms. Proposers are strongly encouraged to complete all proposal forms as specified and include all forms with your proposal. Failure to include proposal forms may be grounds for disqualification from this RFP Process.

Intent of RFP

The City of Clearwater, hereafter known as "the City", is soliciting Dental and Vision insurance for City employees, officials, retirees, COBRA participants and their families. The City's goal is to attain the highest level of professional service, while providing access to a quality network of providers at an affordable cost. The City's plan effective date is January 1, 2025.

CALENDAR

The intended timeline of this RFP is as follows:

- Release of RFP..... 05/02/2024
- Advertise in Tampa Times..... 05/08/2024
- Deadline for receipt of questions.....05/16/2024
- RFP addendum addressing questions released.....05/21/2024
- Deadline to receive proposals.....05/30/2024
- Initial proposal meeting.....06/07/2024
- Best and final offers (BAFO) requested from finalists.....06/14/2024
- Deadline to receive BAFO proposals.....06/24/2024
- Selection Committee Meeting.....07/02/2024
- City Manager/Council to Approve Carrier Selection 08/01/2024
- Open Enrollment Period.....September – October 2024
- Plan Effective Date.....January 1, 2025

This timeline is subject to change.

CONTACT PERSON
Lori Vogel, CPPB
Procurement Manager
Lori.vogel@myclearwater.com

SECTION II: General Information

ADDITIONAL INFORMATION/AMENDMENT Request(s) for additional information or clarifications must be made in writing no later than the date specified in the RFP timeline above.

Changes to this RFP, when deemed necessary, will be completed by written addendum issued prior to the proposal due date. Proposers should not rely on any representations, statements, or explanation other than those made in the RFP or in any addendum to this RFP. Where there appears to be a conflict between the RFP and any addenda issued, the last addendum will prevail.

It is the proposer's responsibility to assure receipt of all addenda. The proposer should verify with the designated contact person prior to submitting a proposal that all addenda have been received. Proposers are required to acknowledge receipt of each addendum issued on the Proposer's Certification form.

PRESENTATIONS/INTERVIEWS Presentations and/or interviews may be requested at the City's discretion. The location for these presentations and/or interviews will be determined by the City and may be held virtually.

COSTS INCURRED BY PROPOSERS All expenses involved with the preparation and submission of proposal to the City, or any work performed in connection therewith, shall be borne by the responding party.

EVALUATION CRITERIA Proposals will be evaluated based on the criteria listed below. A breakdown of points is provided below for 100 total maximum points. The City at its sole discretion may create a short-list of the highest ranked proposals based on evaluation against the evaluation criteria.

No.	Criteria	Maximum Points
1	Proposed Cost	30 Points
2	Benefit Design Strength	30 Points
3	Provider Network Strength	20 Points
4	Customer Service Ability	15 Points
5	Performance Guarantee	5 Points
Total Possible Points		**100 Points**

SECTION II: General Information

ACCEPTANCE/REJECTION OF PROPOSALS

The City reserves the right to reject any and all proposals submitted in response to this RFP, or to cancel, in part or its entirety, this request, if it is in the best interests of the City to do so.

The City reserves the right to accept or reject any or all proposals received as a result of this request, or to negotiate separately with competing proposers simultaneously, and to waive any informalities, defects, or irregularities in any proposal.

The City reserves the right to accept the proposal of a proponent other than that of the lowest proponent.

DISCLOSURE OF PROPOSAL CONTENTS

All material submitted becomes the property of the City. The City has the right to use any or all ideas presented in any reply to this RFP. Selection or rejection of the proposal does not affect this right.

RENEWAL

The awarded firm shall give a minimum of 180 days written notice prior to any renewal date to the city stating specifically what, if any, rate change is proposed.

City Insurance Requirements and Terms & Conditions

The City's insurance requirements and Terms and Conditions are included in the attachments released for this RFP. All vendors are required to review that information prior to submitting their proposal.

SECTION III: Vendor Requirements

- **Proposal Effective Date**: January 1, 2025

- **Commissions**: All carrier proposals to this RFP must be submitted net of broker commissions.

- **Retirees**: Florida Governmental Retirees must be allowed to continue coverage under the City's insurance program as required by Florida Statue 112.08.

- **Reference Requirement:** It is a requirement that all insurance carriers currently provide group insurance to at least three other Municipal entities with at least 2,000 employees. Proposers not able to list three current Municipal entities meeting these requirements as references may be disqualified from consideration.

- **Inquiries**: All questions regarding the document shall be submitted in writing to lori.vogel@myclearwater.com.

SECTION III: Vendor Requirements

- **Proposal Data:** In addition to completion of response forms, proposers are encouraged to include all data relevant to each line of coverage proposal. For example, carriers should provide the following proposal data:

    - Dental Insurance
        - Proposed Benefits
        - Proposed Pricing
        - Network/Provider Disruption Response Data
    - Vision Insurance
        - Proposed Benefits
        - Proposed Pricing
        - Network/Provider Disruption Response Data

- **Guarantees**: Proposers are encouraged to include performance guarantees, implementation guarantees, service guarantees, and network discount guarantees.

- **Rate Guarantees**: Proposers are encouraged to include multi-year rate guarantees for any proposed line of coverage.

- **Plan Implementation**: It is a requirement that the proposer awarded this contract provides representative(s) to assist with implementation, open enrollment, employee communications and ongoing assistance with routine plan administration.

- **Employee Communications:** It is the responsibility of all successful proposers to provide the necessary papers, forms, etc., for initial enrollment and the administration of benefits including but not limited to: brochures outlining schedule of benefits, directories, certificates, claim forms, identification cards, benefit booklets, etc., where applicable.

- **Benefits Administration**: The City has retained Bentek for on-line enrollment and electronic administration of the City's benefit programs, all proposers must have the technological capacity to transmit and accept a HIPAA 834 5010 eligibility file with proper confirmation of receipt and discrepancy reporting.

SECTION IV: Background & Underwriting Information

Carrier History and Funding Arrangement History:

The City currently utilizes four (4) dental plans hereafter known as the low DHMO, mid DHMO, high DHMO, and DPPO. All four (4) of the City's dental plans are fully insured. The low DHMO is currently administered under Sun Life, and the mid DHMO, high DHMO and the DPPO are administered under Cigna. The City's dental renewals for this plan year will be coming through this RFP and will therefore not be an attachment of this RFP.

The City currently utilizes a vision plan administered by Humana. The plan is fully insured. The City's vision rates are currently in rate guarantee and will therefore not be an attachment of this RFP.

Please note, both bundled carrier proposals for multiple lines of coverage as well as standalone proposals for coverage will be considered.

PLAN CHARACTERISTICS

Please take all of the following into consideration in your proposal:

- Currently, all four (4) of the City's dental plans and the City's vision plan are offered via a 3-Tier model (Employee Only, Employee + 1, Employee + 2 or More)
- All dental and vision coverage is voluntary to the employees.

Plan Design Offering History:

- **Dental Insurance**
  - The City has offered their Low DHMO plan through SunLife for 10+ years.
  - The City has offered three dental plans (Mid DHMO, High DHMO, and DPPO) through Cigna since 2018.

- **Vision Insurance**
  - The City has offered their Vision plan through Humana for 10+ years.

SECTION IV: Background & Underwriting Information

Claims Experience Data Provided

The following data is provided for your underwriting team's consideration:

- Dental Claims Experience Data
- Dental Enrollment Data
- Vision Claims Experience Data
- Vision Enrollment Data

Rates and Contribution History (Active Employees)

Low DHMO Plan	2024			2023		
	EE/Month	ER/Month	Total/Month	EE/Month	ER/Month	Total/Month
Employee	$6.50	$0.00	$6.50	$6.50	$0.00	$6.50
Employee + 1	$10.99	$0.00	$10.99	$10.99	$0.00	$10.99
Employee + Family	$17.34	$0.00	$17.34	$17.34	$0.00	$17.34

Low DHMO Plan	2022		
	EE/Month	ER/Month	Total/Month
Employee	$6.50	$0.00	$6.50
Employee + 1	$10.99	$0.00	$10.99
Employee + Family	$17.34	$0.00	$17.34

Mid DHMO Plan	2024			2023		
	EE/Month	ER/Month	Total/Month	EE/Month	ER/Month	Total/Month
Employee	$16.35	$0.00	$16.35	$16.35	$0.00	$16.35
Employee + 1	$30.42	$0.00	$30.42	$30.42	$0.00	$30.42

Employee + Family	$39.59	$0.00	$39.59	$39.59	$0.00	$39.59

Mid DHMO Plan	2022		
	EE/Month	ER/Month	Total/Month
Employee	$16.35	$0.00	$16.35
Employee + 1	$30.42	$0.00	$30.42
Employee + Family	$39.59	$0.00	$39.59

High DHMO Plan	2024			2023		
	EE/Month	ER/Month	Total/Month	EE/Month	ER/Month	Total/Month
Employee	$20.45	$0.00	$20.45	$20.45	$0.00	$20.45
Employee + 1	$38.08	$0.00	$38.08	$38.08	$0.00	$38.08
Employee + Family	$49.57	$0.00	$49.57	$49.57	$0.00	$49.57

High DHMO Plan	2022		
	EE/Month	ER/Month	Total/Month
Employee	$20.45	$0.00	$20.45
Employee + 1	$38.08	$0.00	$38.08
Employee + Family	$49.57	$0.00	$49.57

DPPO Plan	2024			2023		
	EE/Month	ER/Month	Total/Month	EE/Month	ER/Month	Total/Month
Employee	$37.68	$0.00	$37.68	$37.68	$0.00	$37.68
Employee + 1	$76.35	$0.00	$76.35	$76.35	$0.00	$76.35

Employee + Family	$112.56	$0.00	$112.56	$112.56	$0.00	$112.56

DPPO Plan	2022		
	EE/Month	ER/Month	Total/Month
Employee	$37.68	$0.00	$37.68
Employee + 1	$76.35	$0.00	$76.35
Employee + Family	$112.56	$0.00	$112.56

Vision Plan	2024			2023		
	EE/Month	ER/Month	Total/Month	EE/Month	ER/Month	Total/Month
Employee	$5.12	$0.00	$5.12	$5.12	$0.00	$5.12
Employee + 1	$10.24	$0.00	$10.24	$10.24	$0.00	$10.24
Employee + Family	$13.69	$0.00	$13.69	$13.69	$0.00	$13.69

Vision Plan	2022		
	EE/Month	ER/Month	Total/Month
Employee	$5.12	$0.00	$5.12
Employee + 1	$10.24	$0.00	$10.24
Employee + Family	$13.69	$0.00	$13.69

SECTION IV: Background & Underwriting Information

Other Important Information for Underwriting

- Dental Renewal Rates are not yet available at the time of release of this RFP.

EMPLOYEE ELIGIBILITY and Benefit Deductions:

Eligible employees working a minimum of 30 hours per week will be eligible to participate in the City's Dental and Vision benefit offerings.

Coverage will be effective on the first day of the month following the date of hire. For example, if an employee is hired on April 11, then the effective date of coverage will be May 1.

Benefit Deductions: 24 Annual Benefit Deductions.

SECTION V: Response Forms

Exhibit I: Dental Plan Response Form – Please Complete Below Form

		Current	Proposed (Please Fill out the Chart Below)
Sample Procedures		**Sun Life**	
Basic	**Code**	**Low DHMO**	
Periodic Exam	D0120	$0	
Office Visit	D9430	$10	
Prophylaxis	D1110	$0	
Full Mouth X-rays	D0210	$0	
Pediatric Provider Age Limitation		No Limitation	
Extraction			
Single Tooth	D7111	$20	
Partial Impaction	D7230	$75	
Boney Impaction	D7240	$100	
Fillings			
Amalgam - 1 surface	D2140	$10	
Resin - 1 surface	D2330	$35	
Sedative	D2940	$15	
Root Canal Therapy			
Anterior	D3310	$135	
Bicuspid	D3320	$195	
Molar	D3330	$245	
Periodontic Therapy			
Root Planning (1/4)	D4341	$50	
Gingivectomy (1/4)	D4210	$120	
Crown & Bridge			
Full High Noble Metal	D2790	$265	
Porcelain fused to Metal	D2750	$265	
Dentures			
Partial Denture	D5213	$380 + Lab	
Complete Denture	D5110	$295 + Lab	
Denture Reline (chairside)	D5730	$60	
Denture Reline (lab)	D5750	$95 + Lab	
Orthodontia			
Comprehensive Treatment		25% Discount	
Adult Orthodontia Covered?		Yes	
Rate Guarantee		**12/31/2024**	
EE Only		$6.50	
EE + One		$10.99	
EE + Two or More		$17.34	

		Current	Proposed (Please Fill out the Chart Below)
Sample Procedures		**Cigna**	
Basic	**Code**	**Mid DHMO**	
Periodic Exam	D0120	$0	
Office Visit	D9430	$5	
Prophylaxis	D1110	$0	
Full Mouth X-rays	D0210	$0	
Pediatric Provider Age Limitation		17 Years Old	
Extraction			
Single Tooth	D7111	$5	
Partial Impaction	D7230	$70	
Boney Impaction	D7240	$90	
Fillings			
Amalgam - 1 surface	D2140	$0	
Resin - 1 surface	D2330	$0	
Sedative	D2940	$5	
Root Canal Therapy			
Anterior	D3310	$80	
Bicuspid	D3320	$120	
Molar	D3330	$250	
Periodontic Therapy			
Root Planning (1/4)	D4341	$40	
Gingivectomy (1/4)	D4210	$130	
Crown & Bridge			
Full High Noble Metal	D2790	$185	
Porcelain fused to Metal	D2750	$185	
Dentures			
Partial Denture	D5213	$160	
Complete Denture	D5110	$150	
Denture Reline (chairside)	D5730	$35	
Denture Reline (lab)	D5750	$60	
Orthodontia			
Comprehensive Treatment		$1,344 Child; $1,944 Adult	
Adult Orthodontia Covered?		Yes	
Rate Guarantee		**12/31/2024**	
EE Only		$16.35	
EE + One		$30.42	
EE + Two or More		$39.59	

		Current	Proposed (Please Fill out the Chart Below)
Sample Procedures		**Cigna**	
Basic		**High DHMO**	
Periodic Exam	D0120	$0	
Office Visit	D9430	$0	
Prophylaxis	D1110	$0	
Full Mouth X-rays	D0210	$0	
Pediatric Provider Age Limitation		17 Years Old	
Extraction			
Single Tooth	D7111	$12	
Partial Impaction	D7230	$73	
Boney Impaction	D7240	$120	
Fillings			
Amalgam - 1 surface	D2140	$0	
Resin - 1 surface	D2330	$0	
Sedative	D2940	$13	
Root Canal Therapy			
Anterior	D3310	$12	
Bicuspid	D3320	$31	
Molar	D3330	$280	
Periodontic Therapy			
Root Planning (1/4)	D4341	$96	
Gingivectomy (1/4)	D4210	$220	
Crown & Bridge			
Full High Noble Metal	D2790	$390	
Porcelain fused to Metal	D2750	$380	
Dentures			
Partial Denture	D5213	$575	
Complete Denture	D5110	$500	
Denture Reline (chairside)	D5730	$14	
Denture Reline (lab)	D5750	$170	
Orthodontia			
Comprehensive Treatment		$2,184 Child; $2,904 Adult	
Adult Orthodontia Covered?		Yes	
Rate Guarantee		**12/31/2024**	
EE Only		$20.45	
EE + One		$38.08	
EE + Two or More		$49.57	

	Current		Proposed (Please Fill out the Chart Below)	
SCHEDULE OF BENEFITS	**Cigna DPPO**			
Plan Basics	***In Network***	***Non Network***	***In Network***	***Non Network***
Calendar Year Maximum	$1,100			
Deductibles				
Single	$50	$50		
Family	$150	$150		
Deductible Waived for Preventive + Ortho Services?	Yes	Yes		
Benefits				
Preventative	100%	100%		
Basic	80%	80%		
Major	50%	50%		
Orthodontia (Child only)	50%	50%		
Implants	Not covered			
Service Information				
Out of Network Benefits Payable Level	70th Percentile			
Orthodontia Lifetime Max	$1,000			
Rate Guarantee	**12/31/2024**			
EE Only	$37.68			
EE + One	$76.35			
EE + Two or More	$112.56			

If the City were to raise the Out of Network Benefits payable level to 90th U&C, how much of an increase would that be to your proposed rates?

SECTION V: Response Forms

Exhibit II: Vision Plan Response Form – Please Complete Below Form

		Current		Proposed (Please Fill out the Chart Below)	
SCHEDULE OF BENEFITS		**Humana**			
		In Network	***Non Network***	***In Network***	***Non Network***
Exam Copay		$10	Up to $30		
Frequency					
Exam Copay		12 months			
Lenses		12 months			
Frames		24 months			
Benefits Payable		***Copay***	***Reimbursement***		
Eye Exam		$10	$30		
Single Lenses		$15	$25		
Bifocal Lenses		$15	$40		
Trifocal Lenses		$15	$60		
Lenticular Lenses		$15	$100		
Lenses and Frames		***Reimbursement***	***Reimbursement***		
Contact Lenses (Conventional)		$130 + 15% discount above $130	Up to $104		
Contact Lenses (Disposable)		$130 allowance	Up to $104		
Contact Lenses (Medically Necessary)		Paid in Full	Up to $200		
Frames		$130 + 20% discount above $130	Up to $65		
Rate Guarantee		**Expires 12/31/2025**			
Employee	738	$5.12			
Employee + One	241	$10.24			
Employee + Family	168	$13.69			

SECTION V: Response Forms

Exhibit III: Questionnaire - General Information

1. Are you willing to provide performance guarantees for implementation and servicing of your products? If so, please describe the performance guarantees you are proposing.

2. Do you agree to allow retirees over and under 65 to continue coverage under the same plan at the same rate as active employees as required by Section 112.08, Florida Statutes, for public entities?

3. Provide the name, title, and contact information of the individual who would have direct daily account responsibility for the services you are proposing. If more than one person will be filling this role, please respond with complete information for all.

4. Provide the name, title, and contact information for three (3) references from public entity clients with a minimum of 2,000 employees for at least three (3) years immediately preceding the response due date.

References	**Reference 1**	**Reference 2**	**Reference 3**
Group Name			
Contact Name			
Contact Title			
Contact Phone			
Contact Email			
Coverage/Services Provided			
Length of Time			

SECTION V: Response Forms

5. What is your account service team's average response time to client requests or questions?

6. Describe the services provided by your account service team to the employees.

7. Describe the services provided by your account service team to the Human Resources department.

8. Does your company help facilitate annual open enrollments? a. Onsite meetings? b. Educational materials? c. Printed Materials at no cost?

9. What is your company's current A. M. Best, Moody's and/or Standard and Poor's ratings?

10. Do you utilize any "wrap" or leased networks not negotiated or owned by your company? If yes, what is the name of the network?

11. Describe capabilities available through the member website and mobile app. Please describe further any additional functionality available to the employer as plan administrator.

12. Please specify if the proposer is SSAE 18 / SOC / SAS certified.

Exhibit III: Questionnaire - Data and Reports

1. Describe the reports you will provide regarding the utilization and claims associated with the employee benefits program(s) you are proposing. Please indicate in your description if any of the reports would be provided at an additional cost over the fees associated with the programs.

2. What is your proposed frequency of reporting on utilization experience? Is there a charge for utilization data analysis?

3. Are there any additional fees for reporting? Please provide all reporting options/packages and their associated costs.

4. Will there be online access for claim reports?

5. How often are claim audits conducted and what percentage of claims are audited? If you use a third-party to audit claims, please disclose the name of auditor.

6. How do you identify fraudulent claims and how will you notify the entity?

7. Describe the process for identifying and paying claims which may be subject to subrogation.

8. Will there be online access for claim reports by the Entity and Gehring Group?

SECTION V: Response Forms

Exhibit III: Questionnaire - Implementation and Billing

1. Please provide a brief description of the implementation process, including requirements and timeline.

2. Please confirm the proposer is flexible to modify standard contract language.

3. Please confirm the proposer is willing to waive binder payment requirements.

4. Please confirm the proposer is willing to accept a self-bill for proposed line(s) of coverage.

5. What is the proposer's standard billing snapshot date and grace period for payment?

Exhibit III: Questionnaire - Renewal Planning and Additional Fees

1. Is the proposer willing to provide renewal offer at least 180 days prior to renewal effective date?

2. Are any of the rates proposed contingent on any additional information? If so, please disclose.

3. What additional services are available and at what cost?

4. Would you allow a grace period after the due date of 45 days for payment of an invoice?

5. Please confirm any bundling discounts you are offering here.

SECTION V: Response Forms

Exhibit III: Questionnaire - Enrollment & Implementation Technology

1. Does your company (or third-party) process electronic eligibility files via automation or are manual steps necessary? If manual steps are required to process files, please explain this process and impact on processing time.

2. Does your company outsource the processing of electronic eligibility to a third-party? If so, please provide company name.

3. Please specify if your company (or third-party) accepts the HIPAA 834 5010 file layout as well as all other file layouts accepted for automated enrollment. Please provide applicable coding supplements and other applicable file specification documents.

4. What is your company's (or third party's) standard processing time for electronic eligibility to be updated in all applicable internal systems (eligibility/claims/billing/etc.)? If time varies, please specify for each system.

5. Will your company (or third-party) provide confirmation notification to the group when files are processed? Please provide details related to this notification process (email, requirement of group log into company website, etc.)

6. Please provide implementation time (in days) for the initial set-up of automated enrollment (electronic eligibility) of an established group with your company.

7. Please provide implementation time (in days) for the initial set-up of automated enrollment (electronic eligibility) of a new group with your company.

8. Please provide set-up time needed for changes to file structure, plans, funding strategy, platform changes for an established group with your company. What alternative options does your company provide to receive enrollment should these changes cause a delay in the set-up of the EDI process?

9. Please provide a file testing time frame (in days) for initial set-up and structure changes.

10. Please provide the standard time frame required to process files, generate, and mail member ID cards. What options does the group have if ID card delivery is delayed beyond the plan effective date?

SECTION V: Response Forms

Exhibit III: Questionnaire – Dental

1. Please provide Dental Geo Access Information that illustrates the number of: A. 2 General Dentists within 10 miles B. 2 Pediatric Dentists within 10 miles C. 2 Orthodontists within 10 miles D. 2 Endodontic Dentists within 10 miles E. 2 Periodontic Dentists within 10 miles. The report format should include a breakdown by employee city of residence with the number of employees in that location and the number of providers servicing that location. The report should also include reporting on the number and location of employees who do not meet the above criteria.

2. Detailed plan documents have been included in the attachments section of this RFP. Please outline any differences between current benefit documents and your proposed COCs/SPDs (i.e., is there something that is currently being administered that your company cannot administer in the same way?)

3. For proposers not proposing national network coverage, please describe available access for out-of-state residents (retirees and/or dependents of covered participants).

4. Are you willing to waive the actively at work, dependent non-confinement and pre-existing condition limitation provisions for all members currently enrolled in dental insurance?

5. Is there a missing tooth clause in proposer's quote submission?

6. How does the proposed plan treat coverage for composite (non-amalgam) fillings on posterior teeth, including molar teeth?

7. How does the proposed plan treat coverage for orthodontics in progress?

8. Does the proposed plan include coverage for dental implants?

9. Please outline, in detail, how TMJ claims are handled and the coordination with medical coverage.

10. Please confirm dependent child(ren) eligibility criteria, including age and other limitations. Please confirm the pediatric dentist age limit for each proposed plan.

11. Please confirm reimbursement level for out-of-network benefit payments.

12. Provide the dental disruption reports for the provider lists included in the Attachments Section of the RFP.

13. Please confirm you are able to provide regular claims reporting for Dental. What is the frequency of this reporting?

14. Although not required, dental proposers may provide wellness or discretionary funding as they see fit. If you include a dental fund, please outline the amount and what the funds may be used for.

SECTION V: Response Forms

Exhibit III: Questionnaire - Vision

1. Detailed plan documents have been included in the attachments sections of this RFP. Please outline any differences between Humana's documents and your proposed COCs/SPDs (i.e., is there something that is currently being administered that your company cannot administer in the same way?)

2. Please confirm proposed provider network.

3. For proposers not proposing national network coverage, please describe available access for out-of-state residents (retirees and/or dependents of covered participants).

4. Please confirm if ophthalmologists are included as a part of the proposed vision network.

5. How does the proposed plan cover contact lens fit and follow-up examinations?

6. Is the materials copay applicable to contact lenses?

7. Does your proposal allow members to obtain contact lenses and eyeglasses within the same benefit period?

8. Please confirm how Lasik is covered under your proposed plan.

9. Is the frequency for services (i.e., 12/12/24) based on the plan/calendar year or from date of last service?

10. Please confirm dependent child(ren) eligibility.

11. Provide the dental disruption reports for the provider lists included in the Attachments Section of the RFP.

12. Please provide a Vision Geo Access report as follows: a. One Provider within 10 miles b. Two Providers within 10 miles c. Two Providers within 20 miles. Include number of unique providers and unique locations in the report.

13. Please confirm you are able to provide regular claims reporting for Vision. What is the frequency of this reporting?

SECTION V: Response Forms

Exhibit IV: Other Required Forms

Proposers shall indicate any and all exceptions taken to the provisions or specifications in this solicitation document. Exceptions that surface elsewhere and that do not also appear under this section shall be considered invalid and void and of no contractual significance.

Exceptions (mark one):

****Special Note – Any material exceptions taken to the City's Terms and Conditions may render a Proposal non-responsive.**

_____ No exceptions

_____ Exceptions taken (describe--attach additional pages if needed)

Additional Materials submitted (mark one):

_____ No additional materials have been included with this proposal

_____ Additional Materials attached (describe--attach additional pages if needed)

Acknowledgement of addenda issued for this solicitation:
Prior to submitting a response to this solicitation, it is the vendor's responsibility to confirm if any addenda have been issued.

Addenda Number	Initial to acknowledge receipt

Vendor Name_____ Date: _____

SECTION V: Response Forms

Exhibit IV: Other Required Forms

Company Legal/Corporate Name: _____

Doing Business As (if different than above): _____

Address: _____

City: _____ State: _____ Zip: _____-_____

Phone: _____ Fax: _____

E-Mail Address: _____ Website: _____

DUNS #_____

Remit to Address (if different than above):

Address: _____

City: _____State: ____Zip: _____

Order from Address (if different from above):

Address: _____

City: _____State:_____Zip: _____

Contact for Questions about this proposal:

Name: _____ Fax: _____

Phone: _____ E-Mail Address: _____

Day-to-Day Project Contact (if awarded):

Name: _____ Fax: _____

Phone: _____ E-Mail Address: _____

_____ Certified Small Business

Certifying Agency: _____

_____ Certified Minority, Woman or Disadvantaged Business Enterprise

Certifying Agency: _____

Provide supporting documentation for your certification, if applicable.

SECTION V: Response Forms

Exhibit IV: Other Required Forms

By signing and submitting this Proposal, the Vendor certifies that:

a) It is under no legal prohibition to contract with the City of Clearwater.
b) It has read, understands, and is in compliance with the specifications, terms and conditions stated herein, as well as its attachments, and any referenced documents.
c) It has no known, undisclosed conflicts of interest.
d) The prices offered were independently developed without consultation or collusion with any of the other respondents or potential respondents or any other anti-competitive practices.
e) No offer of gifts, payments or other consideration were made to any City employee, officer, elected official, or consultant who has or may have had a role in the procurement process for the services and or goods/materials covered by this contract.
f) It understands the City of Clearwater may copy all parts of this response, including without limitation any documents and/or materials copyrighted by the respondent, for internal use in evaluating respondent's offer, or in response to a public records request under Florida's public records law (F.S. 119) or other applicable law, subpoena, or other judicial process.
g) Respondent hereby warrants to the City that the respondent and each of its subcontractors ("Subcontractors") will comply with, and are contractually obligated to comply with, all Federal Immigration laws and regulations that relate to their employees.
h) Respondent certifies that they are not in violation of section 6(j) of the Federal Export Administration Act and not debarred by any Federal or public agency.
i) It will provide the materials or services specified in compliance with all Federal, State, and Local Statutes and Rules if awarded by the City.
j) It is current in all obligations due to the City.
k) It will accept such terms and conditions in a resulting contract if awarded by the City.
l) The signatory is an officer or duly authorized agent of the respondent with full power and authority to submit binding offers for the goods or services as specified herein.

ACCEPTED AND AGREED TO:

Company Name: _____

Signature: _____

Printed Name: _____

Title: _____

Date: _____

SECTION V: Response Forms

Exhibit IV: Other Required Forms

SCRUTINIZED COMPANIES AND BUSINESS OPERATIONS WITH CUBA AND SYRIA CERTIFICATION FORM

IF YOUR BID/PROPOSAL IS $1,000,000 OR MORE, THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE BID/PROPOSAL. FAILURE TO SUBMIT THIS FORM AS REQUIRED MAY DEEM YOUR SUBMITTAL NONRESPONSIVE.

The affiant, by virtue of the signature below, certifies that:

1. The vendor, company, individual, principal, subsidiary, affiliate, or owner is aware of the requirements of section 287.135, Florida Statutes, regarding companies on the Scrutinized Companies with Activities in Sudan List, the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or engaging in business operations in Cuba and Syria; and
2. The vendor, company, individual, principal, subsidiary, affiliate, or owner is eligible to participate in this solicitation and is not listed on either the Scrutinized Companies with Activities in Sudan List, the Scrutinized Companies with Activities in the Iran Petroleum Sector List, or engaged in business operations in Cuba and Syria; and
3. Business Operations means, for purposes specifically related to Cuba or Syria, engaging in commerce in any form in Cuba or Syria, including, but not limited to, acquiring, developing, maintaining, owning, selling, possessing, leasing or operating equipment, facilities, personnel, products, services, personal property, real property, military equipment, or any other apparatus of business or commerce; and
4. If awarded the Contract (or Agreement), the vendor, company, individual, principal, subsidiary, affiliate, or owner will immediately notify the City of Clearwater in writing, no later than five (5) calendar days after any of its principals are placed on the Scrutinized Companies with Activities in Sudan List, the Scrutinized Companies with Activities in the Iran Petroleum Sector List, or engaged in business operations in Cuba and Syria.

_____
Authorized Signature

_____
Printed Name

_____
Title

_____
Name of Entity/Corporation

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization on, this _____ day of _____, 20____, by _____ (name of person whose signature is being notarized) as the _____ (title) of _____(name of corporation/entity), personally known _____, or produced _____ (type of identification) as identification, and who did/did not take an oath.

_____
Notary Public

_____
Printed Name

My Commission Expires: _____
NOTARY SEAL ABOVE

SECTION V: Response Forms

Exhibit IV: Other Required Forms

SCRUTINIZED COMPANIES THAT BOYCOTT ISRAEL LIST CERTIFICATION FORM

THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE BID/PROPOSAL. FAILURE TO SUBMIT THIS FORM AS REQUIRED MAY DEEM YOUR SUBMITTAL NONRESPONSIVE.

The affiant, by virtue of the signature below, certifies that:

1. The vendor, company, individual, principal, subsidiary, affiliate, or owner is aware of the requirements of section 287.135, Florida Statutes, regarding companies on the Scrutinized Companies that Boycott Israel List, or engaged in a boycott of Israel; and
2. The vendor, company, individual, principal, subsidiary, affiliate, or owner is eligible to participate in this solicitation and is not listed on the Scrutinized Companies that Boycott Israel List, or engaged in a boycott of Israel; and
3. "Boycott Israel" or "boycott of Israel" means refusing to deal, terminating business activities, or taking other actions to limit commercial relations with Israel, or persons or entities doing business in Israel or in Israeli-controlled territories, in a discriminatory manner. A statement by a company that it is participating in a boycott of Israel, or that it has initiated a boycott in response to a request for a boycott of Israel or in compliance with, or in furtherance of, calls for a boycott of Israel, may be considered as evidence that a company is participating in a boycott of Israel; and
4. If awarded the Contract (or Agreement), the vendor, company, individual, principal, subsidiary, affiliate, or owner will immediately notify the City of Clearwater in writing, no later than five (5) calendar days after any of its principals are placed on the Scrutinized Companies that Boycott Israel List, or engaged in a boycott of Israel.

_____
Authorized Signature

_____
Printed Name

_____
Title

_____
Name of Entity/Corporation

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization on, this _____ day of _____, 20____, by _____ (name of person whose signature is being notarized) as the _____ (title) of _____(name of corporation/entity), personally known _____, or produced _____ (type of identification) as identification, and who did/did not take an oath.

_____
Notary Public

_____
Printed Name

My Commission Expires: _____
NOTARY SEAL ABOVE

SECTION V: Response Forms

Exhibit IV: Other Required Forms

VERIFICATION OF EMPLOYMENT ELIGIBILITY FORM

PER FLORIDA STATUTE 448.095, CONTRACTORS AND SUBCONTRACTORS MUST REGISTER WITH AND USE THE E-VERIFY SYSTEM TO VERIFY THE WORK AUTHORIZATION STATUS OF ALL NEWLY HIRED EMPLOYEES.

THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE BID/PROPOSAL. FAILURE TO SUBMIT THIS FORM AS REQUIRED MAY DEEM YOUR SUBMITTAL NONRESPONSIVE.

The affiant, by virtue of the signature below, certifies that:

1. The Contractor and its Subcontractors are aware of the requirements of Florida Statute 448.095.
2. The Contractor and its Subcontractors are registered with and using the E-Verify system to verify the work authorization status of newly hired employees.
3. The Contractor will not enter into a contract with any Subcontractor unless each party to the contract registers with and uses the E-Verify system.
4. The Subcontractor will provide the Contractor with an affidavit stating that the Subcontractor does not employ, contract with, or subcontract with unauthorized alien.
5. The Contractor must maintain a copy of such affidavit.
6. The City may terminate this Contract on the good faith belief that the Contractor or its Subcontractors knowingly violated Florida Statutes 448.09(1) or 448.095(2)(c).
7. If this Contract is terminated pursuant to Florida Statute 448.095(2)(c), the Contractor may not be awarded a public contract for at least 1 year after the date on which this Contract was terminated.
8. The Contractor is liable for any additional cost incurred by the City as a result of the termination of this Contract.

_____
Authorized Signature

_____
Printed Name

_____
Title

_____
Name of Entity/Corporation

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of ☐ physical presence or ☐ online notarization on, this _____ day of _____, 20____, by _____ (name of person whose signature is being notarized) as the _____ (title) of _____(name of corporation/entity), personally known _____, or produced _____ (type of identification) as identification, and who did/did not take an oath.

_____
Notary Public

_____
Printed Name

My Commission Expires: _____
NOTARY SEAL ABOVE

SECTION VI: Attachments

---------- *For US Mail* ----------

SEALED PROPOSAL

Submitted by:
Company Name:
Address:
City, State, Zip:

RFP #44-24, Dental Insurance & Vision Insurance
Due Date: **May 30, 2024**, **at 10:00PM**

City of Clearwater
Attn: **Procurement Division**
PO Box 4748
Clearwater FL 33758-4748

---------- *For US Mail* ----------

---------- *For Hand Deliveries, FEDEX, UPS or Other Courier Services* ----------
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SEALED PROPOSAL

Submitted by:
Company Name:
Address:
City, State, Zip:

RFP #44-24, Dental Insurance & Vision Insurance
Due Date: **May 30, 2024**, **at 10:00PM**

City of Clearwater
Attn: **Procurement Division**
100 S Myrtle Ave 3rd Fl
Clearwater FL 33756-5520

---------- *For Hand Deliveries, FEDEX, UPS or Other Courier Services* ----------